Alice L. Vessel, D.M.D.

Citadel Terrace Building
685 Citadel Drive East, S-313
Colorado Springs, CO 80909
719-574-2424

RELEASE OF DENTAL RECORDS REQUEST FORM

I ____Date of Birth __________ hereby request a copy of my dental records as detailed below. (You cannot request another adult family-member's records)

Patient Address ____
____
____

Home Phone _____________ Work Phone ______________

I ____hereby request a copy of my dependent children(s) dental records as detailed below. (Under 18 years of age only)

Child's Name ____ Date of Birth ______________
Child's Name ____ Date of Birth ______________
Child's Name ____ Date of Birth ______________

Please state your reason for request of records ____

______ Copy of recent dental x-rays only
______ Copy of treatment record (computer generated only)
______ Copy of specific portion/section of dental records as follows:
____

If you wish to have said requested records forwarded directly to new providing dentist; please complete the following:

Dentist Name ____
Street Address ____
City, State, & Zip Code ____
Business Phone ____

______ No please mail records directly to me. ______ No I will pick up my records.

In accordance with the regulations and state law; there is a cost based fee of $25.00 for making and sending copies.

Signature ____ **Date** ____________________________